DEPARTMENT OF HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
EMERGENCY HEALTH & MEDICAL SERVICES

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

OFFICE OF EMERGENCY HEALTH AND MEDICAL SERVICES
64 New York Avenue, NE Suite 5000 WASHINGTON, DC 20001

EMERGENCY MEDICAL TECHNICIAN RECIPROCITY CHECK LIST

Please forward the following information to our office:

☐ Copy of all current state and local certifications.

☐ Copy of current CPR card, front and back. Make sure it is signed.

☐ Copy of current National Registry card or other national certifications. (Not Required)

List any information not currently available:

ITEM	REASON
_____	_____
_____	_____
_____	_____
_____	_____

Return To: Office of Emergency Health and Medical Services
64 New York Avenue NE Suite 5000
Washington, DC 20001

PLEASE NOTE: The District of Columbia does not issue reciprocity EMS certifications card unless the applicant has a place of employment in the pre-hospital setting in D.C. You will be notified by letter of your eligibility for reciprocity certification.

ENCLOSURES:
EMT Application for Reciprocity
EMS providers located in the District of Columbia
Verification of EMT Status

6/99

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH

Office of Emergency Health and Medical Services
64 New York Avenue,NE Suite 5000 Washington, DC 20001

EMT/BASIC,INTERMEDIATE PARAMEDIC,PARAMEDIC
RECIPROCITY

NAME_____SS#_____
ADDRESS_____APT #_____
CITY_____STATE _____ZIP CODE
TELEPHONE #:(W)_____(H)_____
DATE OF BIRTH:___/___/___AGE:_____SEX:___

-HAVE YOU EVER RECEIVED RECIPROCITY IN THE DISTRICT OF COLUMBIA BEFORE? YES / NO
-HAVE YOU EVER BEEN CERTIFIED AS AN EMS PROVIDER IN THE DISTRICT OF COLUMBIA YES / NO
If yes: Level EMT/B EMT/P Expiration Date:_____
-HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES / NO (If yes,provide complete details on the back of this page, including location, date, court of conviction, and circumstances)

Name/Address - current employer:_____
- D.C. employer:_____

TRAINING COURSE NAME (check all that apply)	DATE COMPLETED	TRAINING INSTITUTION
DOT- EMT/BASIC	_____	_____
DOT- EMT REFRESHER	_____	_____
DOT- EMT/INTERMEDIATE	_____	_____
DOT- PARAMEDIC	_____	_____

CERTIFICATION	LEVEL	NUMBER	EXPIRATION	AGENCY/STATE
NREMT or NREMT/P	_____	_____	_____	NREMT/OHIO
EMT STATE	_____	_____	_____	_____
CPR	_____	_____	_____	_____
BTLS	_____	_____	_____	_____
ACLS	_____	_____	_____	_____
OTHER	_____	_____	_____	_____

**(ENCLOSE COPIES OF ALL CERTIFICATION CARDS, BOTH FRONT AND BACK)

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I RECOGNIZE THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE, AND THAT ANY FALSE INFORMATION GIVEN IN THIS APPLICATION COULD CAUSE REVOCATION OF CERTIFICATION. I AUTHORIZE OEHMS TO VERIFY INFORMATION ON THIS FORM AND TO CONTACT PRESENT AND PREVIOUS EMPLOYERS TO OBTAIN ANY SUCH VERIFICATION.

DATE:_____ SIGNATURE:

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OFFICE USE ONLY

Approved by_____ Date_____ EXP date